Independent File Review: Sudden Death Investigation of Nadine Machiskinic
Regina Police Service - RM15001452

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Scope of Review:

This Independent Review was commissioned by the Regina Police Service through formal correspondence directed to the RCMP - F Division Criminal Operations. Prior to this request, the matter was subject of review by the Saskatchewan Public Complaints Commission and Coroner's Inquest. This review was conducted by the Major Crime Program under a defined mandate to determine if the substantive investigation met the necessary standard to be accepted as a professional, sudden death investigation. Specifically, the review was to consider best practices and the application of the nine defined and universally accepted principles of Major Case Management:

- The Command Triangle
- Communication
- Leadership and Team Building
- Managerial Considerations
- Crime Solving Strategies
- Ethical Considerations
- Accountability Mechanisms
- Legal Considerations
- Partnerships

In addition, the reviewers were tasked to assess the investigative techniques applied, the viability of alternative investigative strategies, and the presence of investigational and/or evidentiary deficiencies with a view of providing recommendations for future application.

Background:

On January 10, 2015, Nadine Machiskinic, a twenty nine year old Indigenous woman, was found in medical distress in the basement laundry room of the Delta Hotel at 1919 Saskatchewan Drive in Regina, Saskatchewan. Ms. Machiskinic was discovered by a hotel employee upon his return to the area following evacuation that stemmed from the activation of the hotel fire alarm. At the time of the evacuation there was no sign of Ms. Machiskinic and the area was unremarkable. Once clearance was given by the Regina Fire Department, the employees returned to their duties and Ms. Machiskinic was found lying on the floor near the laundry chute. She was in clear medical distress and emergency medical personnel were called to the hotel and offered treatment based on their assessment of the scene. Based on their observations, Ms. Machiskinic was treated for a suspected drug overdose and transported to the Regina General hospital where she died a short time later. It could not be established if Ms. Machiskinic's medical intervention included consideration or treatment for any condition outside of a suspected drug overdose.

Following an investigation by the Provincial Coroner's Office, the preliminary cause of death was deemed to be the result of a drug overdose with no apparent criminal element to her death. An autopsy was ordered and scheduled to be performed at the Pasqua Hospital on January 12, 2015. At the onset of the external examination by Dr. Cabigon, he discovered posterior rib fractures that were inconsistent with the application of CPR. These injuries impacted the preliminary cause of death and were reported to the Coroner who notified the Regina Police Service of the circumstances and need to investigate. That afternoon, major crime officers attended the Pasqua Hospital and met the Coroner and Pathologist to assess the injuries and circumstances surrounding the death. The officers were briefed on the findings and they personally observed the external trauma which included significant bruising throughout Ms. Machiskinic's face and body.

The investigators left the Pasqua Hospital and attended to the Delta Hotel where they met the Director of Operations, Mr. Ian Johnson. The officers viewed the laundry room and chute area and were briefed on the particulars of the fire alarm activation that occurred the morning of January 10, 2015. The fire alarm was activated on the tenth floor, which at the time, was occupied by only one registered guest. The guest was William Creeden, a business traveller from the United States, who was checked into room 1008. Mr. Creeden reportedly called the front desk at or near the time of the fire alarm to report a suspicious female knocking on doors and warning of a fire. Of significance, room 1008 was in proximity to the service room that housed the laundry chute. The fire alarm pull station is located immediately adjacent to the service room. It was at this time, investigators confirmed the hydraulic assembly on the service room door was malfunctioning and incapable of closing the door completely after its release, thus creating unfettered access to the room and laundry chute.

It is not abundantly clear who had last contact with Ms. Machiskinic prior to her death but Mr. Creeden appears to be one of, if not the last person, to have had contact with her. Unfortunately, there remains uncertainty, due in part to the inability of investigators to identify

two men who appeared to share an elevator with Ms. Machiskinic in the minutes before the fire alarm, and prior to her contact with Mr. Creeden. Mr. Creeden's account of the incident was received nearly a year after the fact and creates additional uncertainty due to his claim the female who knocked on his door was in the company of two children.

A forensic autopsy was subsequently performed by Dr. Shaun Ladham on January 15, 2015 at the Saskatoon City Hospital and revealed Ms. Machiskinic died as a result of blunt force trauma of her head and torso, consistent with a fall down the laundry chute present at the scene.

The investigation has not quelled the concerns of the family and has been subject of intense public and media interest.

Executive Summary:

Prior to undertaking this review, the reviewers had only a superficial knowledge of the circumstances surrounding Nadine Machiskinic's death. The investigation was subject of two external review processes as led by the Saskatchewan Public Complaints Commission and the Office of the Chief Coroner via Coroner's Inquest. Neither of these processes, their findings, or recommendations, were reviewed or relied upon for the purposes of preparing this report. The findings and recommendations included here are solely based on a review of the investigative material as provided by the Regina Police Service.

The focus of this report was not to provide commentary on policy compliance or to assess the investigative theory or findings, but rather to assess the investigative process itself. The reviewers do not support the sudden death investigation of Nadine Machiskinic as meeting the standards of a professional, sudden death investigation. This finding is the direct result of the absence of a Command Triangle and an effective Case Management system to manage the investigation. While elements of the nine Major Case Management principles were demonstrated, Accountability Mechanisms were also deemed to be lacking and seen as detrimental to the investigation. Despite this finding, the investigation demonstrated critical thinking and best practices in some aspects, notwithstanding the significant challenges posed by the delay in police notification.

Nine Principles of Major Case Management:

The nine principles of Major Case Management (MCM) have become widely accepted as the foundation for conducting a professional police investigation into any serious or complex crime. They are a product of best practices and lessons learned from a cross section of agencies and investigations. With specific courses on the subject matter taught at the Canadian Police College, MCM is considered the standard for Canadian Law Enforcement.

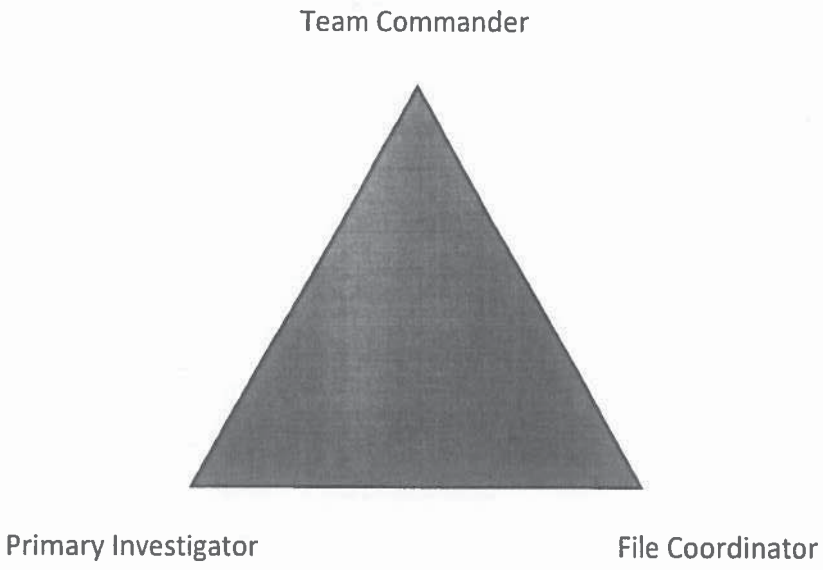
1) Command Triangle

The Command Triangle (CT) is at the core of Major Case Management and is comprised of a Team Commander, Primary Investigator, and File Coordinator. Each member of the CT has a specific role and responsibility:

Team Commander (TC): responsible to manage the overall investigation.

Primary Investigator (PI): responsible to manage the speed, flow and direction of the investigation.

File Coordinator (FC): responsible for managing the investigative work product and disclosure.



The Command Triangle drives the investigation and the subsequent actions of the Coordinated Investigative Team (CIT).

Based on the investigative material provided for review, there was no evidence found to support that a Command Triangle was established or considered. It was evident that major crime investigators led the investigation from the onset of police involvement and they sought assistance from the Forensic Identification Unit to assist with several facets of the investigation. The investigative team was comprised of two major crime investigators at the rank of Detective Sergeant who managed the investigation. After approximately one year, two new investigators of equal rank, were assigned to the matter and replaced the first pair of investigators. There was evidence to indicate the newly reassigned investigators undertook a file review but the extent of their efforts and the transition process could not be established from the documentation provided for review.

Recommendation 1: Consider practical and formalized training opportunities to develop a cadre of Team Commanders within the organization. The Canadian Police College currently offers the Major Case Management: Team Commander (MCMTC) course.

Recommendation 2: Apply the Command Triangle and assign personnel permanently to the roles of Team Commander, Primary Investigator, and File Coordinator. These roles and the performance of the respective duties are the foundation to ensure a professional investigation by law enforcement.

Recommendation 3: Apply a concerted team effort in the early stages of the investigation to maximize investigative opportunities. [Despite the delay in the matter being reported to police, several investigative avenues could have been pursued simultaneously by expanding the number of investigators available to assist and "front end load" the investigation.]

Case Management

The investigative material provided for review was supplied by the Access and Privacy Officer in digital format as requested. The material was contained on twenty nine individually titled discs. The investigation was case managed using the IEIS (Integrated Electronic Information System) which is a Niche RMS product. The investigative reports were arranged chronologically by the date the report was authored.

Based on the investigative material provided for review, but for one exception, there was no evidence found to support the use or consideration of any formal tasking or tracking mechanism in which to assign investigative tasks or monitor their completion. The sole exception related to a report authored by Det/Sgt. Criddle and related to his efforts to obtain the call records from the RPS Communications Centre. The report dated January 13, 2015, is titled "Task 01.103 Communications Centre Call".

In preparation for the review, the investigative material required consolidation into one digital medium for ease of access and reference. The fact the material was sorted chronologically by date, rather than by task, required additional time in which to review and ensure adequate sourcing was in place for the recommendations.

Recommendation 4: Apply a formal tasking methodology to all major case investigations from the onset. There are a range of options to effectively task/track investigational work product including a Task Ledger, Windows File Tree, Niche RMS, PowerCase, and Evidence and Reports III to name a few.

Business Rules/Standard Operating Procedures

Business Rules define the Standard Operating Procedures that guide operations and assist the Coordinated Investigative Team (CIT) in achieving investigational goals. Business rules can be applied on multiple levels but at a minimum should define the investigational responsibilities and file flow for the CIT. On a basic level this would clarify protocols for the creation and submission of tasks, review, vetting, naming conventions, and hold back evidence to name a few. As desired, this approach could be applied to define specific expectations for individuals and/or groups of contributors. For example, this might direct that all investigative interviews utilize audio/video recording, clarify the statements to be transcribed, and the format for the data file to be provided to the File Coordinator.

In any Major Case Investigation, Business Rules should be created and implemented at the onset of the investigation. Once established, these rules need to be communicated and reviewed by the entire CIT including support staff. It is recommended that a system be implemented to verify all team members have reviewed the Business Rules. The Business Rules should then be retained on file for reference and accompanied by any revisions and the date of implementation. Any changes should be communicated to the CIT and acknowledged by way of documentation.

Based on the investigative material provided for review, there was no record found to suggest Business Rules were created or implemented.

Recommendation 5: Establish Business Rules to guide Major Case investigations that are consistent with Best Practices as well as the capacity and policy of your organization.

2) Communication

Investigational Briefings:

Investigational Briefings are paramount to the successful resolution of a serious investigation. Briefings are well-structured, formalized discussions and are critical to support the exchange of information amongst the investigative team and to maintain a high level of engagement and accountability from the various contributors. Briefings also serve as an opportunity to clarify the status of outstanding tasks, identify new tasks for the investigation, and to brainstorm ideas. Briefings should be led by the Command Triangle and include all contributors whenever possible. A summary of the items discussed and conclusions reached should be recorded by a designate and serve as a single point of reference for the investigative team.

Decisions of significance, and the rationale in support of those decisions, should be documented by way of a Decision Log for future reference, to aid future court testimony, and to promote accountability measures. The rationale might include a record of internal/external factors that steered a team toward a certain investigative strategy or belief. The Decision Log should also detail any environmental changes or limitations that led to a particular investigative action or eliminated the feasibility of other strategies from being applied or further considered.

Based on the investigative material provided for review, there was no evidence, notwithstanding the police notes of Detective Sergeant Troy Davis, to support the existence of investigational briefings. The reviewers were unable to clarify the nature of these briefings, the content of discussion, the nominal roll, or the impact on the investigation. There was no documentation in support of how the investigation was going to be approached on January 12, 2015, or the developing "investigative theory". In this instance, the reviewers suggest properly documented investigational briefings would have provided clarity in the identification of investigational strategies, considerations, and overall accountability.

Recommendation 6: Apply regular and formal investigational briefings as a means to drive investigations of significance and leverage the collective knowledge and skills of the team. Maintain a written record of those in attendance and a summary of the items discussed. Ensure the results of completed tasks are shared with the team and that newly identified tasks are assigned to ensure accountability.

Recommendation 7: Apply a Decision Log to record significant decisions and include rationale that influenced the decision.

Communication is the responsibility of all team members and its importance, specifically in the context of investigational briefings, can't be overstated. It is the opinion of the reviewers that poor communication existed between the Major Crime and Forensic Identification investigators, and this posed one of the more significant detriments to the investigation.

Based on the investigative material provided for review, the Major Crime investigators and the Forensic Identification investigators appeared to work in isolation of one another. There was no evidence or documentation to suggest they mutually discussed or planned a course of action to manage the seized evidence. This was evidenced by the seizure of biological samples at the autopsy and the subsequent delay in the exhibits being sent to the lab for analysis. On two documented occasions, a Major Crime investigator called the Coroner's Office to inquire about the status of toxicology results, when in fact the biological exhibits remained in the possession of the Forensic Identification Unit. This produced additional delays and hampered the ability of the investigators to advance the investigation. In particular, there was a documented, deliberate decision to delay the interview with [redacted] pending receipt of the toxicology results.

3) **Leadership and Team Building**

The reviewers recognized considerable efforts were applied by each respective pair of investigators during the investigation. Based on the investigative material provided for review, there was no clear evidence to demonstrate that any of the individual contributors assumed a leadership role during the investigation. It did not appear that anyone was tasked as the Primary Investigator or File Coordinator to ensure investigational tasks were identified, assigned, or reviewed as was needed to ensure completion and quality control.

4) **Managerial Considerations**

Based on the investigative material provided for review, there was no documentation found to clarify the role that management played, or their level of influence, during the investigation. The sole reference found in the investigative material relates to a text message sent by [redacted] to Detective Sergeant Trithart that requested he call the Coroner, Maureen Stinnen to discuss a sudden death from the weekend "that may now be suspicious".

Managerial Considerations are a derivative of a Team Commander's critical thinking, a level of oversight commensurate with his/her level of experience, and ability to reflect on the significance of issues beyond the substantive investigation. The role of Team Commander within an investigation is invaluable, not only to ensure the quality of investigation but to serve as the nexus with Senior Management and ensure policy and other relevant circumstances are considered.

In this case, there was no documentation present to indicate managerial engagement, review, or oversight of the investigation outside of travel approval late in the investigation. Likewise there was no evidence found of upward reporting and/or managerial engagement from the investigators. The single exception to this was found in a notebook entry that identified the presence of management at meetings with the Coroner's Office which appeared to coincide with the pending Coroner's Inquest.

Recommendation 8: If not currently in place, establish a formalized process to update Senior Management of serious investigations and/or significant developments.

5) **Crime Solving Strategies (and Assessment of Investigative Techniques)**

Medical Facilities:

There is indication that Major Crime investigators read Ms. Machiskinic's intake records at the hospital but it did not appear a copy was requested or provided by the Coroner for the investigation. It is not expected these records would alter the direction of the investigation but in the spirit of thoroughness, and possibly for future investigational reference, copies of all medical records should be obtained during the course of investigation.

Recommendation 9: Obtain copies of all medical records relating to the treatment provided to Ms. Machiskinic by Emergency Medical Services, the Regina General Hospital, and Pasqua Hospital pursuant to the Coroner's Act.

Delta Hotel:

The investigation met exceptional challenges from the onset due to the delayed police notification. The Regina Police Service were not dispatched to the Delta Hotel upon Ms. Machiskinic's discovery on January 10, 2015. As a consequence, police were not afforded the opportunity to immediately assess the scene for themselves and form their own belief as to what may have transpired. This set off a chain reaction that prevented police from securing the laundry room and the tenth floor service room for forensic examination and their ability to immediately interview witnesses. The circumstances also contributed to Ms. Machiskinic's personal items, including her shoes and duffel bag, becoming lost and unrecoverable.

The investigation met additional and unfortunate challenges presented by gaps in the surveillance video at the Delta Hotel. The inoperability of several cameras led to poor coverage of the facility that would otherwise be expected to shed light on the incident and related circumstances. Moreover, the investigation established the Incident Reports of the hotel staff were unreliable and missing valuable information.

Based on the investigative material provided for review, a hotel "Guest List" was requested on January 12, 2015 by Major Crime investigators. The request was documented in officer notes but the "Guest List" was not obtained until another formal request was made pursuant to the Coroner's Act on February 3, 2016. Once obtained, the list had partially purged. The inability to secure a Guest List at the onset of the investigation prevented a full scale canvass of the registered guests at the onset of the investigation. Such an effort may have aided investigators to confirm or disprove Mr. Creeden's recollection that Ms. Machiskinic was in the company of children when she knocked on his door. Given the fire alarm, and subsequent inoperability of hotel elevators, one might assume that if the children were guests in the hotel, they might have been displaced from their family at the time of evacuation.

On January 12, 2015, the investigators were provided access and information by the Director of Operations for the Delta Hotel, Mr. Ian Johnson. Investigators were provided access to the basement laundry room and viewed the laundry chute via the second floor. They also viewed pertinent areas on the tenth floor including the service room that served as access to the laundry chute. The service room was situated in proximity to the fire alarm pull station and Room 1008, which Mr. Johnson advised was the only room occupied on the tenth floor during the morning of January 10, 2015. During this preliminary attendance to the scene, the investigators observed the glass tube normally located under the lever of the fire alarm pull station was missing. All other fire alarm pull stations were intact on the tenth floor. The investigators also manually tested and confirmed the auto close mechanism on

the service room door was malfunctioning and allowed the door to remain ajar after its release.

Upon learning that Room 1008 had been relinquished by the patron, the investigators requested no one be allowed to enter or clean the room until inspected and possibly processed by their Forensic Identification Unit. Mr. Johnson agreed to comply with the request. There is a notation in Det/Sgt. Trithart's notes that a lock was to be placed in the door to room 1008 but the reviewers could not ascertain if this was done. The Forensic Identification investigator documented that when he arrived the door was locked but the manner was not established.

Beyond the police request, it could not be established what efforts were undertaken to prevent access to either the service room or room 1008. Given the importance to the investigation, the reviewers believed that greater efforts should have been undertaken to preserve the integrity of these potential and actual scenes. It could not be established if the Forensic Identification Unit was unavailable to attend or not called until the following day.

Recommendation 10: Deploy the necessary support services at the earliest opportunity to process a suspected crime scene. If the required resources are not immediately available, consider deploying a guard to maintain the integrity of the scene.

Forensic Identification Unit:

On January 13, 2015, investigators with the Forensic Identification Unit attended the Delta Hotel and photographed the basement laundry area. The dimensions of the laundry chute opening and its distance from the floor were recorded. The laundry chute was also photographed via the second floor where the direction of travel deviates before entry to the basement laundry room.

Investigators proceeded to the tenth floor to examine and photograph the service room and laundry chute access. The dimensions of the opening and distance from the ground were recorded but the Forensic Identification investigator deemed the surface of the chute access door and its frame unsuitable for processing. The fire alarm pull station was observed and the glass rod was intact indicating replacement since the previous day.

Based on the photographs depicting the frame of the laundry chute and surrounding surface area, the reviewers believed both surfaces, as well as the lever of the fire alarm pull station, were at the least, worthy of an attempt to dust for fingerprints and swab for trace biological samples.

Recommendation 11: Consider the delegation of a dedicated Crime Scene Manager as part of your CIT to ensure every possible avenue is considered and exhausted with respect to evidence collection and processes.

Room 1008 was processed and led to the discovery of several items of unknown but potential significance to the investigation. In particular, was the discovery of black hair fibres and the wrapper from a feminine hygiene product. The origin of these items remain a source of uncertainty given Mr. Creeden's assertion that he had not invited or allowed any women into his room. Mr. Creeden's denial did not come to light until his interview on February 5, 2016.

Cell Phone examination:

Ms. Machiskinic's cell phone was seized by the Forensic Identification Unit at the Pasqua Hospital on January 12, 2015 and subsequently turned over to Major Crime investigators on January 14, 2015. Based on the investigative material, it was not clear if this cell phone was immediately examined at the time of exchange. The documentation is suggestive that the contents were actioned by investigators on January 28, 2015. It is the opinion of the reviewers that, had the cell phone been examined immediately upon its seizure, investigators may have learned of Ms. Machiskinic's attendance at Casino Regina earlier in the investigation. This may have produced an opportunity to view and seize surveillance video from the casino which may have shed light on Ms. Machiskinic's activities and/or associates prior to her death.

The cell phone review revealed names and contact information of people Ms. Machiskinic contacted earlier in the day and near the time of her death. The reviewers could not offer any comment regarding the sufficiency of the manual examination of Ms. Machiskinic's cell phone but believed it prudent to consult with the Technological Crime Section to establish if additional information could be retrieved.

Other Surveillance Video:

On January 23, 2015, an investigator contacted the Casino Regina to inquire about surveillance video. The investigator learned the video surveillance was subject of a ten day purge and was no longer available. This inquiry also established that Ms. Machiskinic's "Player Card" had been activated the morning of January 10, 2015 at 2:09 a.m.

There was no documentation found in which to determine if other businesses in the vicinity were canvassed for surveillance video.

Crime Analyst:

In January 2016, there is documentation to indicate the new Major Crime investigators were attempting to build a timeline to outline Ms. Machiskinic's activities before her death. The reviewers believed this could have been valuable to the investigation and that efforts could have been undertaken to solicit the assistance of a Crime Analyst to assist in collating the information from multiple sources and create some form of visual aid to reference. The reviewers also believed there was a potential role for an analyst with respect to pursuing subscriber information gleaned from Ms. Machiskinic's cell phone. This role could have expanded to include efforts to identify persons of interest sooner in the investigation. Specifically, an outgoing text message from Ms. Machiskinic on January 9, 2015 said "I'm chillin w my home girl, Charity on Elephant St."

To date, Major Crime investigators have been unable to identify "Charity" who was named by Ms. Machiskinic in text messages and separately by [redacted]. As documented in police notes, Major Crime investigators met with Ms. Machiskinic's family on January 14, 2015. During that meeting they learned [redacted] told the family that Ms. Machiskinic had been at McDonald's in the afternoon with "Charity" and "Chocolate Bob". There was no documentation found to indicate "Chocolate Bob" was ever identified or interviewed.

Recommendation 12: Consider the use of a Crime Analyst to support the CIT to manage background queries and collate evidence.

Witness Statements:

None of the witness interviews taken during the course of the investigation were transcribed and both reviewers believed this would have benefited the review process and the investigation, particularly during transition.

The interviews that were conducted using audio/video recording were consistent with "Best Practices". There were two handwritten statements as provided by the EMS employees who treated Ms. Machiskinic at the Delta Hotel and transported her. These statements were requested on January 13, 2015, but not retrieved until January 27, 2015. There was no indication of follow up by investigators and the reviewers believed these witnesses could have potentially provided additional information beyond what was volunteered in their concise accounts of the incident.

The reviewers observed that a number of potential witnesses were spoken to only via telephone. While unavoidable in some circumstances, this process was applied to both non-local and some local witnesses. This was applied during efforts to track down the two "unidentified males" who potentially shared an elevator with Ms. Machiskinic. The reviewers agreed with the assessment of the investigators, the two men were not considered suspects. Nevertheless, a great deal of importance was placed on efforts by police to identify and interview them. On May 9, 2016, [redacted] made reference in his police notes of "possible male #1" [redacted] and "possible male #2" [redacted]. From the documentation provided, the methodology used to identify these two males as "possible" was unclear and there was no task or report generated to capture the investigative step.

It appeared that [redacted] was eventually contacted by the investigators via telephone and emailed the surveillance photograph from the hotel. He subsequently denied being the man in the photograph and/or elevator. It could not be established if [redacted] was contacted by investigators.

There was a marked delay in effecting the interviews with the Delta Hotel employees. The first of two interviews taken from Joseph Pelletier, the night security guard was on January 22, 2015. Mr. Pelletier recalled an encounter with a male guest on the tenth floor as he was investigating the fire alarm. Mr. Pelletier recalled the guest telling him he heard kids running around ten to fifteen minutes before the alarm. He also said the female knocked at his door near the time of the alarm. An interview with Mr. Johnson followed the next day

and [redacted] who worked the front desk was interviewed on February 5, 2015. The other front desk employee [redacted] moved to India before he could be interviewed.

[redacted] was not interviewed by police until June 2, 2015, despite being described by investigators "as a person considered to be close to Machiskinic and knew about her life and daily routines". [redacted] was in custody at the time of Ms. Machiskinic's death and remained there until at least until the time of his interview. It did not appear the interview was recorded, nor was there any record that investigators inquired about the identities of "Charity" or "Chocolate Bob". Had efforts been made to corroborate this information early in the investigation, it may have gleaned valuable information regarding Ms. Machiskinic's activities leading up to her attendance at the hotel.

Despite the wealth of information that could have been gleaned early on from William Creeden, he was not interviewed until February 5, 2016. Major Crime investigators began their efforts to track down Mr. Creeden on February 2, 2015 when investigators contacted the Kansas City Police (KCP). On February 3, 2015, investigators emailed [redacted] (KCP) to request background information on Mr. Creeden. Based on the documentation provided for review, there were no copies of the request or the subsequent reply, if any, to the request for information. On August 11, 2015, investigators established contact by telephone with [redacted], a lawyer who represented the Boiler Maker's Association. [redacted] advised of Mr. Creeden's ill health but agreed to relay the investigator's message that he was seeking to interview Mr. Creeden. On August 12, 2015, [redacted] contacted the investigator and read an emailed response on behalf of Mr. Creeden. The investigator documented the content of the message verbatim in his police notes. It was at this time that Mr. Creeden said the female, who knocked on his hotel door, was in the direct company of young children. The reviewers observed that Mr. Creeden appeared cooperative with investigators, particularly when they met in person for the audio/video recorded witness interview. By this time the Forensic Lab had ruled out the hair fibres in room 1008 as belonging to Ms. Machiskinic. Regardless, Mr. Creeden maintained that no females had been in his room.

Recommendation 13: Retain all pertinent email correspondence that is not transitory in nature.

Other Investigative Avenues:

Despite the operating theory that Mr. Creeden was not a suspect, the black hair fibres and feminine hygiene product wrapper found in his room, appeared to create potential delays in interviewing him. The reviewers recognized an opportunity outside of having to rely on Mr. Creeden to explain the findings. The reviewers believed interviews with Housekeeping staff might have clarified the origin of the items found in room 1008 and shed light on the possibility that housekeeping accessed the room and initiated cleaning before the initial police attendance. This avenue was also considered by the second pair of investigators who made note to request a "housekeeping log" but there was no documentation found to suggest the avenue was pursued.

The reviewers could not find any documentation to suggest investigators focused on the piece of Delta stationary that was found on Ms. Machiskinic's person during the autopsy on January 12, 2015. The paper contained two handwritten names and a phone number and was seized and exhibited by the Forensic Identification investigator. The reviewers found evidence the phone number was called by investigators and found to be out of service, but it is unclear if further efforts were attempted. There was no documentation to suggest the link was made between the phone number called by Ms. Machiskinic prior to her entering the Delta Hotel, and the number written on the Delta Stationary located in her jacket pocket. The fact that this number was called prior to her entering the hotel, suggests that she obtained the stationary sometime prior to entering the hotel.

On April 7, 2017, [redacted] attended the front desk of the Regina Police Service of his own volition to share information. [redacted] reported that an acquaintance by the name of [redacted], who used to live in Lemburg but moved to Regina, bore resemblance to one of the males in the photographs shared by police. The report indicated a task was sent to Major Crimes but there was no documentation found to indicate if [redacted] was identified or interviewed.

The interview of [redacted] on May 31, 2017 was unsolicited and detailed his stated personal contact with Ms. Machiskinic prior to her death. At the onset, [redacted] account seemed credible with potential for corroboration through additional witness interview. Despite exceptional efforts by the investigators, the account could not be corroborated by the independent witnesses named by [redacted]. As a result, the information appeared unreliable and was reflective of fabrication. [redacted] was not re-interviewed and challenged on his misinformation, nor was any motivation identified for his attempt to inject himself into the investigation.

6) Ethical Considerations

The review did not find any situation that was suggestive of ethical breach or dilemma.

7) Accountability Mechanisms

Prior to this review, the investigation was subject of multiple review processes that identified investigational and procedural shortcomings. These shortcomings have been publicly acknowledged by the Regina Police Service who requested the current review to demonstrate transparency and their desire to address the concerns of the Machiskinic family.

It is the belief of the reviewers that Accountability Measures were inadequate during the investigation and that application of the Command Triangle and an improved Case Management system could have avoided pitfalls and promoted more timely collection of evidence to the benefit of the investigation and stakeholders.

The reviewers recognized that many of the necessary investigative steps were identified, some were not actioned in a timely manner, and a slight few not at all. The most apparent cause for the oversight was the absence of a formalized tasking and tracking mechanism. The suggested remedy would also promote the enhanced organization of the investigational material by specific task for ease of reference, review, or disclosure purposes.

8) Legal Considerations

The investigation was managed pursuant to provincial legislation and provisions outlined in *The Coroner's Act, 1999*. This approach was found by the reviewers to be reasonable and appropriate to the circumstances. The powers outlined within the Act, were sufficient to support the investigation and allow for the collection of evidence. The investigation was not hampered by this approach and based on the investigative material available for review, provisions of the *Criminal Code* were not a viable option to the investigative team.

Investigators rightfully seized the opportunity to process room 1008 of the Delta Hotel after it was relinquished by William Creeden. The significance of the room, or the potential for linkage to Ms. Machiskinic's death was unknown at the time that it was processed, but in doing so, investigators put to rest a great deal of speculation that would have otherwise followed Mr. Creeden and the investigation. No warrant was required, nor did sufficient grounds exist at the time, or now, for the judicially authorized search of room 1008. That said, it was evident that investigators were cautious with respect to Mr. Creeden's potential jeopardy in the investigation. This appeared to have contributed to the lengthy delay in effecting his interview. While it was apparent that such Legal Considerations were being made, this decision making process could have been clarified and enhanced through the application of a "Decision Log" for reasons already discussed above.

9) Partnerships

The reviewers recognized the existence of two essential partnerships with the Regina Police Service as driven by the investigation. The importance of the partnership with the local Coroner and the Office of the Chief Coroner are front of mind. The dynamic circumstances that caused the preliminary cause of death to be reconsidered required immediate communication, action, and ongoing consultation between the Coroner and police. The partnership was essential and the powers of the Coroner served as the instrument to advance the investigation and obtain evidence such as the Guest List from the Delta Hotel. The frequency and product of the discussions between the Coroner and investigative team could be clarified and perhaps enhanced through the establishment of a task and reporting specific to the client. For example, the determination to request the expanded toxicology report is one issue that may have been articulated through documentation.

Another obvious partnership was that between the Machiskinic family and police. Ms. Delores Stevenson has served as the primary point of contact for the family and, since the onset of the investigation, the partnership has produced information valuable to

investigators. The partnership, though perhaps somewhat strained, remains of great importance to both parties.

Recommendation 14: Create a specific task and document contact with essential partners during the course of an investigation.

Conclusion:

The reviewers acknowledge the skills and dedication of the investigators who contributed to the various aspects of the investigation. Hindsight tends to provide a level of clarity that investigators are not afforded when the investigation is moving in real time. It is also valuable to recognize the recommendations offered by the reviewers are a product of their own "lessons learned".

It was the mutual belief of the reviewers that the investigators efforts likely surpassed what was demonstrated through documentation. There were other intangible factors the reviewers considered such as the impact of shift scheduling considerations and/or the availability of other major crime resources to assist. Reviewers speculated that initial delays in investigative steps at the onset of the investigation were consistent with regular time off entitlements. It was not clear if overtime was available to further the investigation or if other options were available to prevent urgent tasks from sitting idle.

Superintendent Derek Williams,
Officer in Charge - "F" Division Major Crimes

Staff Sergeant Brent Olberg,
"F" Division – General Investigation Section Manager

Corporal Evan Anderson,
"F" Division – Major Crime North

Recommendations

Recommendation 1:

Consider practical and formalized training opportunities to develop a cadre of Team Commanders within the organization. The Canadian Police College currently offers the Major Case Management: Team Commander (MCMTC) course.

Recommendation 2:

Apply the Command Triangle and assign personnel permanently to the roles of Team Commander, Primary Investigator, and File Coordinator. These roles and the performance of the respective duties are the foundation to ensure a professional investigation by law enforcement.

Recommendation 3:

Apply a concerted team effort in the early stages of the investigation to maximize investigative opportunities. [Despite the delay in the matter being reported to police, several investigative avenues could have been pursued simultaneously by expanding the number of investigators available to assist and "front end load" the investigation.]

Recommendation 4:

Apply a formal tasking methodology to all major case investigations from the onset. There are a range of options to effectively task/track investigational work product including a Task Ledger, Windows File Tree, Niche RMS, PowerCase, and Evidence and Reports III to name a few.

Recommendation 5:

Establish Business Rules to guide Major Case investigations that are consistent with Best Practices as well as the capacity and policy of your organization.

Recommendation 6:

Apply regular and formal investigational briefings as a means to drive investigations of significance and leverage the collective knowledge and skills of the team. Maintain a written record of those in attendance and a summary of the items discussed. Ensure the results of completed tasks are shared with the team and that newly identified tasks are assigned to ensure accountability.

Recommendation 7:

Apply a Decision Log to record significant decisions and include rationale that influenced the decision.

Recommendation 8:

If not currently in place, establish a formalized process to update Senior Management of serious investigations and/or significant developments.

Recommendation 9:

Obtain copies of all medical records relating to the treatment provided to Ms. Machiskinic by Emergency Medical Services, the Regina General Hospital, and Pasqua Hospital pursuant to the Coroner's Act.

Recommendation 10:

Deploy the necessary support services at the earliest opportunity to process a suspected crime scene. If the required resources are not immediately available, consider deploying a guard to maintain the integrity of the scene.

Recommendation 11:

Consider the delegation of a dedicated Crime Scene Manager as part of your CIT to ensure every possible avenue is considered and exhausted with respect to evidence collection and processes.

Recommendation 12:

Consider the use of a Crime Analyst to support the CIT to manage background queries and collate evidence.

Recommendation 13:

Retain all pertinent email correspondence that is not transitory in nature.

Recommendation 14:

Create a specific task and document contact with essential partners during the course of an investigation.